



### MEDICAL HISTORY SURVEY

1. Do you have now or have you had in the past, problems with (check yes or no for each area listed):

	YES	NO
Headaches Requiring Treatment		
Heart		
Breathing (i.e. asthma)		
Abdominal Pain		
Dizzy Spells / Fainting		
Black Outs		
Eyes (except glasses)		
Hearing or Ears		
Arthritis		
Joint Pain or Swelling		
Knees (i.e. injury, giving out, swelling)		
Spine (Back or Neck)		
Broken Bones		
Kidneys		
Bladder		
Diabetes		
High Blood Pressure		
Cancer		
Operations or Surgery		
Varicose Veins		
Skin Disorders		
Other Major Injuries		
Drug Allergies		
Eating Disorder		
Allergies		
Numbness or Tingling in Arms, Hands, Legs or Feet		
Skin Rashes		

2. Have you had any problems with the following muscle, tendon, bone or joint areas (check yes or no for each area listed):

	YES	NO
Head		
Neck		
Back		
Chest		
Shoulder		
Upper Arm		
Elbow		
Forearm		
Wrist		
Hand		

	YES	NO
Fingers		
Hip		
Thigh		
Knee		
Shin		
Calf		
Ankle		
Foot		
Toes		

3. If you answered YES to any of item in questions 1 or 2, please provide details:

---



---

4. What physical activities have you been doing in the last two months?

---

---

---

5. Have you ever been knocked unconscious and/or had a seizure? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

6. Have you ever had a cervical spine injury? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

7. Are you under a physicians care at the present time? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

8. Are you taking any medications or drugs at the present time? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

9. Are you taking any supplements at the current time? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

10. Do you have a permanent handicap or disability? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

11. Have you ever had any problems during or after exercise such as passing out, dizziness or chest pains? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

12. Have you ever become ill from exercising in the heat? \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

---

---

13. Please provide any other pertinent information not asked on this form.

---

---